FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C.

Address: 2649 E. 75th Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: 773-356-9300 **Fax #** 773-356-9384

IDPA ID Number: 36-4209295-001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Edward Slack, C.P.A.	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	68,023	7,031	5,317	80,371	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,023	7,031	5,317	80,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.50%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/18/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/28/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 5,202

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILIT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	315,634	50,340	20,170	386,144		386,144	(2,172)	383,972			1
2	Food Purchase		284,705		284,705	(7,510)	277,195	336	277,531			2
3	Housekeeping	215,046	64,313		279,359		279,359	2,854	282,213			3
4	Laundry	88,909	29,285		118,194		118,194		118,194			4
5	Heat and Other Utilities			199,860	199,860		199,860	2,189	202,049			5
6	Maintenance	63,939		105,505	169,444		169,444	17,119	186,563			6
7	Other (specify):*			150,714	150,714		150,714	2,843	153,557			7
8	**TOTAL General Services**	683,528	428,643	476,249	1,588,420	(7,510)	1,580,910	23,169	1,604,079			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	2,410,405	76,470	37,142	2,524,017		2,524,017	15,688	2,539,705			10
10a	Therapy	78,053	3,015	8,440	89,508		89,508	2,660	92,168			10a
11	Activities	137,327	10,609	6,085	154,021		154,021	(1,034)	152,987			11
12	Social Services	89,168		4,702	93,870		93,870	(2,150)	91,720			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							8,840	8,840			15
16	**TOTAL Health Care and Programs**	2,714,953	90,094	61,369	2,866,416		2,866,416	24,005	2,890,421			16
	C. General Administration											
17	Administrative	32,695		291,871	324,566		324,566	46,131	370,697			17
18	Directors Fees											18
19	Professional Services			358,781	358,781		358,781	(326,253)	32,528			19
20	Dues, Fees, Subscriptions & Promotions			64,466	64,466		64,466	(38,859)	25,607			20
21	Clerical & General Office Expenses	170,166	31,979	294,114	496,259		496,259	(97,889)	398,370			21
22	Employee Benefits & Payroll Taxes			566,375	566,375	7,510	573,885	(22,251)	551,635			22
23	Inservice Training & Education			2,045	2,045		2,045		2,045			23
24	Travel and Seminar			5,411	5,411		5,411	6,347	11,758			24
25	Other Admin. Staff Transportation			1,098	1,098		1,098	375	1,473			25
26	Insurance-Prop.Liab.Malpractice			83,748	83,748		83,748	1,458	85,206			26
27	Other (specify):*							33,394	33,394			27
28	**TOTAL General Administration**	202,861	31,979	1,667,909	1,902,749	7,510	1,910,259	(397,546)	1,512,713			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,601,342	550,716	2,205,527	6,357,585		6,357,585	(350,372)	6,007,213			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C.
0042119
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	7,510	
2	FOOD		7,510

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTE #0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,201	33,201		33,201	433,373	466,574			30
31	Amortization of Pre-Op. & Org.							9,567	9,567			31
32	Interest			70,642	70,642		70,642	1,761,348	1,831,990			32
33	Real Estate Taxes			277,646	277,646		277,646	2,965	280,611			33
34	Rent-Facility & Grounds			1,063,933	1,063,933		1,063,933	(1,045,531)	18,402			34
35	Rent-Equipment & Vehicles			12,090	12,090		12,090	4,670	16,760			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,457,512	1,457,512		1,457,512	1,166,392	2,623,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,107	350,699	511,806		511,806	(3,546)	508,260			39
40	Barber and Beauty Shops			16	16		16		16			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,760	131,760		131,760		131,760			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		161,107	482,475	643,582		643,582	(3,546)	640,036			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,601,342	711,823	4,145,514	8,458,679		8,458,679	812,474	9,271,153			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(68,984)	30		9
10	Interest and Other Investment Income	(17,942)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,060)	21		18
19	Entertainment				19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,000)	21		24
25	Fund Raising, Advertising and Promotional	(17,494)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(28,350)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(25,448)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (357,776)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,170,250		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,170,250		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 812,474		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C.

ID# 0042119

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Misc. Income - Jury Duty	(166)	10	2
3	Bank Charges	(1,310)	21	3
4	Collection Expense	(3,176)	21	4
5	Theft/Loss	(4,255)	21	5
6	Trust Fees (Bldg. Co.)	(235)	20	6
7	Bank Charges (Bldg. Co.)	(45)	21	7
8	Meal Income	(25)	2	8
9	Non-Care Asset Depreciation	(3,436)	30	9
10	Architect Fees (Bldg. Co.)	(1,068)	19	10
11	Appraisal Fees (Bldg. Co.)	(5,000)	19	11
12	Survey Fees (Bldg. Co.)	(450)	19	12
13	Legal Fees (Bldg. Co.)	(6,282)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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83				83
84				84
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86				86
87				87
88				88
89				89
90	Total	(25,448)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTI # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			6,810	(8,760)		(222)						(2,172)	1
2	Food Purchase	(273)		(1,448)			2,057						336	2
3	Housekeeping			2,854									2,854	3
4	Laundry													4
5	Heat and Other Utilities			2,189									2,189	5
6	Maintenance			17,916	(806)		9						17,119	6
7	Other (specify):*			2,742			101						2,843	7
8	**TOTAL General Services**	(273)		31,063	(9,566)		1,945						23,169	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(166)		34,557	(32,319)	22,538	1		(8,923)				15,688	10
10a	Therapy			6,675	(4,015)								2,660	10a
11	Activities			2,895	(3,929)								(1,034)	11
12	Social Services			2,552	(4,702)								(2,150)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,956		2,884							8,840	15
16	**TOTAL Health Care and Programs**	(166)		52,635	(44,964)	25,422	1		(8,923)				24,005	16
	C. General Administration													
17	Administrative			46,077	(75,676)	75,676	54						46,131	17
18	Directors Fees													18
19	Professional Services	(12,800)	12,800	12,131	(338,400)		16						(326,253)	19
20	Fees, Subscriptions & Promotions	(18,979)	235	1,781	(21,900)		4						(38,859)	20
21	Clerical & General Office Expenses	(235,196)	45	164,101	(26,892)		53						(97,889)	21
22	Employee Benefits & Payroll Taxes				(22,251)								(22,251)	22
23	Inservice Training & Education													23
24	Travel and Seminar			6,344			3						6,347	24
25	Other Admin. Staff Transportation			282			93						375	25
26	Insurance-Prop.Liab.Malpractice			1,458									1,458	26
27	Other (specify):*			24,244		9,150							33,394	27
28	**TOTAL General Administration**	(266,975)	13,080	256,418	(485,118)	84,826	223						(397,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(267,414)	13,080	340,116	(539,648)	110,248	2,169		(8,923)				(350,372)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(72,420)	490,483	15,310									433,373	30
31	Amortization of Pre-Op. & Org.		9,567										9,567	31
32	Interest	(17,942)	1,762,710	16,577			3						1,761,348	32
33	Real Estate Taxes			2,965									2,965	33
34	Rent-Facility & Grounds		(1,051,200)	5,669									(1,045,531)	34
35	Rent-Equipment & Vehicles			4,665			5						4,670	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(90,362)	1,211,560	45,186			8						1,166,392	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,546)						(3,546)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(3,546)						(3,546)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(357,776)	1,224,640	385,302	(539,648)	110,248	(1,369)		(8,923)				812,474	45

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		South Shore Properties, LLC - Chicago		Building Company
				SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,051,200	South Shore Properties, LLC	100.00%	$	$ (1,051,200)	1
2	V	32	Interest Expense		South Shore Properties, LLC	100.00%	1,762,710	1,762,710	2
3	V	19	Appraisal Fee		South Shore Properties, LLC	100.00%	5,000	5,000	3
4	V	19	Survey		South Shore Properties, LLC	100.00%	450	450	4
5	V	19	Architect Fees		South Shore Properties, LLC	100.00%	1,068	1,068	5
6	V	21	Bank Charges		South Shore Properties, LLC	100.00%	45	45	6
7	V	20	Trust Fees		South Shore Properties, LLC	100.00%	235	235	7
8	V	19	Legal		South Shore Properties, LLC	100.00%	6,282	6,282	8
9	V	31	Amortization Closing Costs		South Shore Properties, LLC	100.00%	9,567	9,567	9
10	V	30	Depreciation		South Shore Properties, LLC	100.00%	490,483	490,483	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,051,200			$ 2,275,840	$ * 1,224,640	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 6,810	$ 6,810	15
16	V	2	FOOD				(1,448)	(1,448)	16
17	V	3	HOUSEKEEPING				2,854	2,854	17
18	V	5	UTILITIES				2,189	2,189	18
19	V	6	REPAIRS AND MAINT.				17,916	17,916	19
20	V	7	EMP. BEN. - GEN. SERV.				2,742	2,742	20
21	V	10	NURSING				34,557	34,557	21
22	V	10A	THERAPY				6,675	6,675	22
23	V	11	ACTIVITIES				2,895	2,895	23
24	V	12	SOCIAL SERVICES				2,552	2,552	24
25	V	15	EMP. BEN. - HEALTHCARE				5,956	5,956	25
26	V	17	ADMINISTRATIVE				46,077	46,077	26
27	V	19	PROFESSIONAL FEES				12,131	12,131	27
28	V	20	DUES, SUBSCRIPTIONS				1,781	1,781	28
29	V	21	CLERICAL AND GENERAL				164,101	164,101	29
30	V	24	SEMINARS				6,344	6,344	30
31	V	25	AUTO EXPENSE				282	282	31
32	V	26	INSURANCE				1,458	1,458	32
33	V	27	EMP. BEN. - GEN. ADMIN.				24,244	24,244	33
34	V	30	DEPRECIATION				15,310	15,310	34
35	V	32	INTEREST				16,577	16,577	35
36	V	33	REAL ESTATE TAXES				2,965	2,965	36
37	V	34	BUILDING RENT - UNRELATED				5,669	5,669	37
38	V	35	EQUIPMENT RENTAL				4,665	4,665	38
39	Total			$			$ 385,302	$ * 385,302	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,760	Care Centers, Inc.	100.00%	$ 0	$ (8,760)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	28,800			0	(28,800)	17
18	V	19	BOOKEEPING	48,960			0	(48,960)	18
19	V	19	DATA PROCESSING	8,640			0	(8,640)	19
20	V	19	LEGAL	21,900			0	(21,900)	20
21	V	19	MANAGEMENT FEE	201,600			0	(201,600)	21
22	V	19	PROFESSIONAL FEES	13,500			0	(13,500)	22
23	V	20	ADVERTISING	21,900			0	(21,900)	23
24	V	25	REBILL BUS	0			0		24
25	V						0		25
26	V	22	HOME OFFICE PAYROLL TAX	22,251			0	(22,251)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	806			0	(806)	29
30	V	10	REBILL. PAYROLL NURSING	32,319			0	(32,319)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,015			0	(4,015)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,929			0	(3,929)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	4,702			0	(4,702)	33
34	V	17	REBILL. PAYROLL ADMIN.	75,676			0	(75,676)	34
35	V	21	REBILL. PAYROLL CLERICAL	26,892			0	(26,892)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 539,648			$ 0	$ * (539,648)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 22,538	$ 22,538	15
16	V	15	EMP. BEN HEALTHCARE				2,884	2,884	16
17	V	17	ADMINISTRATIVE				75,676	75,676	17
18	V	27	EMP. BEN GEN. ADMIN.				9,150	9,150	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 110,248	$ * 110,248	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 1,062	$ 1,062	15
16	V	2	FOOD				2,057	2,057	16
17	V	6	MAINTENANCE				9	9	17
18	V	7	EMP. BEN. - GEN. SERV.				101	101	18
19	V	10	NURSING				1	1	19
20	V	17	ADMINISTRATIVE				54	54	20
21	V	19	PROFESSIONAL FEES				16	16	21
22	V	20	DUES, FEES, SUB.				4	4	22
23	V	21	CLERICAL & GENERAL				53	53	23
24	V	24	SEMINARS				3	3	24
25	V	25	TRAVEL				93	93	25
26	V	32	INTEREST				3	3	26
27	V	35	RENT - EQUIPMENT & VEHICLES				5	5	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				69	69	28
29	V	1	DIETARY SUPP	1,284			0	(1,284)	29
30	V	39	ANCILLARY SUPP	3,615			0	(3,615)	30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,899			$ 3,530	$ * (1,369)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 47,039	$ 47,039	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	55,962				(55,962)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,962			$ 47,039	$ * (8,923)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 67,632	$ 67,632	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	67,632				(67,632)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 67,632			$ 67,632	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SOUTH SHORE NURSING & REHABILI # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0%	See Attached	2.6	3.61%	Mgmt. Fees	$ 180,000	17-3	1
2	James Goodsite	Owner	Administrative	.83%	See Attached	2.66	5.32%	Alloc. Salary	6,918	17-7	2
3	David Aronin	Owner	Administrative	.83%	See Attached	2.66	5.32%	Alloc. Salary	4,659	17-7	3
4	Gordon Brown	Owner	Administrative	.83%	See Attached	2.66	5.32%	Alloc. Salary	3,381	17-7	4
5	Mark Steinberg	Relative	Administrative	0%	See Attached	2.66	5.32%	Alloc. Salary	2,358	17-7	5
6	Sandy Bokor	Relative	Administrative	0%	See Attached	1	2.86%	Mgmt. Fees	12,000	17-3	6
7	Alan Abrams	Owner	Administrative	.83%	See Attached	1	2.86%	Mgmt. Fees	12,000	17-3	7
8	Ronald Abrams	Owner	Administrative	.83%	See Attached	1	2.00%	Mgmt. Fees	12,000	17-3	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 233,316		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	80,371	$ 6,810	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		80,371	(1,448)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	80,371	2,854	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		80,371	2,189	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	80,371	17,916	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		80,371	2,742	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	80,371	34,557	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	80,371	6,675	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	80,371	2,895	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	80,371	2,552	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		80,371	5,956	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	80,371	46,077	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		80,371	12,131	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		80,371	1,781	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	80,371	164,101	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		80,371	6,344	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		80,371	282	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		80,371	1,458	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		80,371	24,244	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		80,371	15,310	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		80,371	16,577	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		80,371	2,965	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		80,371	5,669	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		80,371	4,665	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 385,302	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		22,538	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			2,884	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		75,676	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			9,150	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 110,248	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS HEALTH SYSTEMS
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	4,899	1,062	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		4,899	2,057	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		4,899	9	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		4,899	101	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		4,899	1	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		4,899	54	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		4,899	16	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		4,899	4	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		4,899	53	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		4,899	3	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		4,899	93	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		4,899	3	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		4,899	5	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		4,899	69	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 3,530	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 47,039	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 47,039	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 67,632	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 67,632	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NURSING & REHABILIT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X				$	$			$ 50,048	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daiwa Loan		X	Line of Credit				509,202			16,653	6
7	Intercompany Loan	X									3,941	7
8												8
9	TOTAL Facility Related						$	$ 509,202			$ 70,642	9
	B. Non-Facility Related*											
10	Supplemental Schedule							14,996,306			1,779,290	10
11	Interest Income										(17,942)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 14,996,306			$ 1,761,348	14
15	TOTALS (line 9+line14)						$	$ 15,505,508			$ 1,831,990	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITAT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	DUE TO SHAREHOLDERS	X		LOAN			$	$ 1,265,770			$ 941,179	1
2	CORUS BANK - SS PROP, LLC	X		MORTGAGE LOAN				9,964,071			783,550	2
3	CIB BANK - SS PROP, LLC	X		2ND MORTGAGE LOAN				3,766,465			37,981	3
4	CCI ALLOCATION	X		ALLOCATION							16,577	4
5	HEALTH SYSTEMS ALLOC	X		ALLOCATION							3	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 14,996,306			$ 1,779,290	21

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	277,936	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	269,102	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,834)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	289,445	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	280,611	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998	108,397	11
1999	266,137	12

2000 accrual is 1999 taxes paid of $266,137 * 1.05 = $279,444

Line 2 includes CCI Allocation of R/E taxes paid of $2,965.

Prior Year accrual (line 1) was corrected to reflect $10,000 accrual for related property.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior BRICK Frame STEEL & MASONRY Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 9,567
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LONG TERM CARE	101,000	1994	$ 352,000	1
2	CARE CENTERS ALLOCATION			3,401	2
3	TOTALS	101,000		$ 355,401	3

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOW CLEANING			1998	1,900	49	20	95	46	245	9
10	ADDL BLDG LEGAL FEES			1998	491		20	25	25	25	10
11	FIRE ALARM BOX			1998	1,988	51	20	99	48	256	11
12	TELE CABLING			1998	603	15	20	30	15	78	12
13	SIGNS			1998	1,000	26	20	50	24	121	13
14	CABLING			1998	508	13	20	25	12	60	14
15	SIGN LETTERING			1998	2,500	64	20	125	61	292	15
16	SECURITY SYSTEM			1998	3,500	90	20	175	85	408	16
17	SIGNS			1998	573	15	20	29	14	68	17
18	BALLASTS			1998	501	13	20	25	12	58	18
19	SECURITY SYSTEM			1998	3,786	97	20	189	92	425	19
20	ELECTRICAL			1998	710	18	20	36	18	81	20
21	SECURITY SYSTEM			1998	3,800	97	20	190	93	412	21
22	PLUMBING			1998	837	21	20	42	21	91	22
23	ADDL BLDG LEGAL FEES			1999	1,953		20	98	98	98	23
24	PAGE 12-2 REP TOTALS				75,778	2,016		2,512	496	10,092	24
25	PAGE 12-1 REP TOTALS				11,725,819	309,249		335,240	25,991	827,193	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				62,362	1,335		2,696	1,361	3,014	35
36	TOTAL (lines 4 thru 35)				$ 11,888,609	$ 313,169		$ 341,681	$ 28,512	$ 843,017	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WIRING			1999	13,000	333	20	650	317	758	9
10	HVAC RENOV			1999	1,796	46	20	90	44	98	10
11	SIGN			1999	2,240	57	20	112	55	187	11
12	A/C UPGRADE			1999	3,800	97	20	190	93	317	12
13	ELEVATOR PARTS			2000	558	5	20	12	7	12	13
14	BOILER RENOV			2000	967	24	20	48	24	48	14
15	TV WIRING			2000	18,268	410	20	837	427	837	15
16	CABLING			2000	952	19	20	40	21	40	16
17	PLUMBING RENOV			2000	894	16	20	34	18	34	17
18	WATER HEATER			2000	9,417	171	20	353	182	353	18
19	HVAC			2000	4,562	63	20	133	70	133	19
20	HVAC			2000	5,908	94	20	197	103	197	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 62,362	$ 1,335		$ 2,696	$ 1,361	$ 3,014	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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14											14
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16											16
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	$ 11,715,725	$ 309,249	35	$ 334,735	$ 25,486	$ 826,183	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE - SOUTH SHORE BUILDING CO.			1998	10,094		20	505	505	1,010	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,725,819	$ 309,249		$ 335,240	$ 25,991	$ 827,193	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	CCI Alloc	$ 60,196	$ 1,544	35	$ 1,720	$ 176	$ 7,023	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARE CENTERS, INC - ALLOCATION			1993		6			(6)		9
10	CARE CENTERS, INC - ALLOCATION			1994		20			(20)		10
11	CARE CENTERS, INC - ALLOCATION			1996	6,940	92		334	242	1,146	11
12	CARE CENTERS, INC - ALLOCATION			1997	6,314	144		348	204	1,687	12
13	CARE CENTERS, INC - ALLOCATION			1998	445	11		22	11	59	13
14	CARE CENTERS, INC - ALLOCATION			1999	1,078	28		54	26	102	14
15	CARE CENTERS, INC - ALLOCATION			2000	73	1		3	2	3	15
16	CARE CENTERS, INC - ALLOCATION			1997	732	170		31	(139)	72	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 75,778	$ 2,016		$ 2,512	$ 496	$ 10,092	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATI(# 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,050,613	$ 214,232	$ 119,959	$ (94,273)		$ 293,248	37
38	Current Year Purchases	12,332	1,962	523	(1,439)		523	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,062,945	$ 216,194	$ 120,482	$ (95,712)		$ 293,771	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	CARE CENTERS ALLOCATION			$ 28,593	$ 6,195	$ 4,411	$ (1,784)		$ 9,899	42
43										43
44										44
45										45
46	TOTALS			$ 28,593	$ 6,195	$ 4,411	$ (1,784)		$ 9,899	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,335,548	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 535,558	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 466,574	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (68,984)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,146,687	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	KFC Building	$ 134,000	$ 3,436	$ 6,729	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 134,000	$ 3,436	$ 6,729	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C.
0042119
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
SOUTH SHORE NURSING & REHABILITATION CENTER	119,608	29,829	11,964	(17,865)	19,985
CARE CENTERS, INC.	51,051	6,605	5,519	(1,086)	23,666
SOUTH SHORE PROPERTIES, LLC - BLDG CO.	879,954	177,798	102,476	(75,322)	249,597
TOTALS	1,050,613	214,232	119,959	(94,273)	293,248
LINE 29: CURRENT YEAR					
SOUTH SHORE NURSING & REHABILITATION CENTER	9,456	1,468	456	(1,012)	456
CARE CENTERS, INC.	2,876	494	67	(427)	67
SOUTH SHORE PROPERTIES, LLC - BLDG CO.					
TOTALS	12,332	1,962	523	(1,439)	523
LINE 30: FULLY DEPRECIATED					
SOUTH SHORE NURSING & REHABILITATION CENTER					
CARE CENTERS, INC.					
SOUTH SHORE PROPERTIES, LLC - BLDG CO.					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
SOUTH SHORE NURSING & REHABILITATION CENTER	129,064	31,297	12,420	(18,877)	20,441
CARE CENTERS, INC.	53,927	7,099	5,586	(1,513)	23,733
SOUTH SHORE PROPERTIES, LLC - BLDG CO.	879,954	177,798	102,476	(75,322)	249,597
TOTALS	1,062,945	216,194	120,482	(95,712)	293,771

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party Lease

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from CCI		240		5,669			5
6	KFC Building				12,733			6
7	TOTAL		240		$ 18,402 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,760 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 130,012	$		$ 130,012	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			63,067			63,067	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			157,619			157,619	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				88,243		88,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						72,864		72,864	13
14	TOTAL			$		$ 350,698	$ 161,107		$ 511,805	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	33,102
2	Specialty Beds	20,732
3	Oxygen	1,000
4	Respiratory Supplies	3,694
5	Laboratory	3,134
6	Ambulance Service	800
7	Radiology	3,733
8	Enteral Supplies	6,669
9		
10		
		72,864

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENT # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,299	$ 9,260	1
2	Cash-Patient Deposits	47,262	47,262	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,899,068	2,899,068	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,221	25,221	6
7	Other Prepaid Expenses	5,813	5,813	7
8	Accounts Receivable (owners or related parties)	1,025,994	1,025,994	8
9	Other(specify): See supplemental schedule	28,340	28,340	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,039,997	$ 4,040,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		12,209,725	14
15	Leasehold Improvements, at Historical Cos	84,568	84,568	15
16	Equipment, at Historical Cost	129,067	1,008,022	16
17	Accumulated Depreciation (book methods)	(58,754)	(1,475,144)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,515	3,515	22
23	Other(specify): See supplemental schedule		102,016	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 158,396	$ 12,284,702	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,198,393	$ 16,325,660	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 642,316	$ 642,316	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,067	47,067	28
29	Short-Term Notes Payable	509,202	1,774,972	29
30	Accrued Salaries Payable	188,974	188,974	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,476	27,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)	279,445	289,445	32
33	Accrued Interest Payable			33
34	Deferred Compensation	834	834	34
35	Federal and State Income Taxes	23,350	23,350	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,718,664	$ 2,994,434	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,730,536	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,730,536	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,718,664	$ 16,724,970	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,479,729	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,198,393	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CE! # 0042119 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow	28,340	28,340			
	28,340	28,340			

OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Net Loan Closing Costs		102,016			
		102,016			

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 487,013	1	
2	Restatements (describe):		2	
3	Schedule attached	589,829	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,076,842	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,762,887	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(360,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,402,887	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,479,729	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SOUTH SHORE NURSING & REHAE #	0042119	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,076,842
Adjustments:		
		-
		-
		-
Proceeds from Sale of Stock		(800,000)
Prior year Equity Adjustment		(55,000)
Adjustment to Bad Debt Expense		261,000
Decrease in Short Term Assets		4,171
Total adjustments		(589,829)
Balance - Beginning of Year		487,013
Equity(Deficit) from Page 17 Col 1		2,479,729
Related Party		
Equity(Deficit)	-1654400	
Income	-1224640	
		(2,879,040)
Combined Equity - End of Year		(399,311)

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATIO # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,903,744	1
2	Discounts and Allowances for all Levels	(1,237,911)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,665,833	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,174,094	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,174,094	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	25	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,152	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,589	19
20	Radiology and X-Ray	7,124	20
21	Other Medical Services	240,641	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 363,531	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,942	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,942	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	166	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 166	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,221,566	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,588,420	31
32	Health Care	2,866,416	32
33	General Administration	1,902,749	33
	B. Capital Expense		
34	Ownership	1,457,512	34
	C. Ancillary Expense		
35	Special Cost Centers	511,822	35
36	Provider Participation Fee	131,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,458,679	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,762,887	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,762,887	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOUTH SHORE NURSING & REH # 0042119 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Misc. Income - Jury Duty	166
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	166

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTE # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,160	1,268	$ 34,931	$ 27.55	1
2	Assistant Director of Nursing	2,851	3,259	71,687	22.00	2
3	Registered Nurses	13,196	14,428	289,376	20.06	3
4	Licensed Practical Nurses	53,060	57,661	946,740	16.42	4
5	Nurse Aides & Orderlies	124,887	134,882	1,044,629	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,604	7,219	78,052	10.81	8
9	Activity Director	2,032	2,328	28,024	12.04	9
10	Activity Assistants	14,370	15,392	109,303	7.10	10
11	Social Service Workers	9,020	9,822	89,168	9.08	11
12	Dietician					12
13	Food Service Supervisor	4,203	4,821	59,408	12.32	13
14	Head Cook	6,471	6,896	58,060	8.42	14
15	Cook Helpers/Assistants	28,069	29,834	198,166	6.64	15
16	Dishwashers					16
17	Maintenance Workers	5,306	5,738	63,939	11.14	17
18	Housekeepers	31,111	32,868	215,046	6.54	18
19	Laundry	12,876	13,785	88,909	6.45	19
20	Administrator					20
21	Assistant Administrator	1,944	2,315	32,695	14.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,488	16,609	170,166	10.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,171	2,591	23,043	8.89	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	333,819	361,716	$ 3,601,342 *	$ 9.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	505	$ 20,170	1-3	35
36	Medical Director	Monthly	5,000	10-3	36
37	Medical Records Consultant	Monthly	4,368	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	455	10-3	39
40	Physical Therapy Consultant	35	1,750	10a-3	40
41	Occupational Therapy Consultant	39	1,950	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	725	10a-3	43
44	Activity Consultant	47	2,156	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Other Consultants (see attached)		44,965		47
48					48
49	TOTAL (lines 35 - 48)	641	$ 81,539		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATIO # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator paid thru CCI			$ 0
Brent Fitzgerald	Asst Administrator	0	32,695
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 32,695

B. Administrative - Other

Description	Amount
Management Fees - See Attached	$ 216,195
CCI Administrator	75,676
TOTAL (agree to Schedule V, line 17, col. 3)	$ 291,871
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 22,135
Care Centers Inc.	Data Processing	8,640
Alpha Data Services	Data Processing	6,449
MaxSource	Data Processing	800
Source Tech	Data Processing	1,035
Personnel Planners, Inc.	Unemployment Consultant	1,662
Care Centers Inc.	Medicaid Application Consult	13,500
Care Centers Inc.	Bookkeeping Services	48,960
Care Centers Inc.	Home Office Expenses	201,600
Care Centers Inc.	Ancillary Admin Services	28,800
Care Centers Inc.	Accounting Services	15,000
Frost, Ruttenberg & Rothblatt	Accounting Services	10,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 358,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,731
Unemployment Compensation Insurance	83,763
FICA Taxes	275,757
Employee Health Insurance	76,409
Employee Meals	7,510
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	2,113
Chicago Head Tax	19,006
Misc. Employee Welfare	7,345
TOTAL (agree to Schedule V, line 22, col.8)	$ 551,634

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,327
Health Care Worker Background Check	
(Indicate # of checks performed 404)	4,842
Licenses & Fees	8,843
Dues & Subscriptions	6,610
Advertising & Promotion	17,494
CCI Allocation	1,781
Less: Public Relations Expense	( )
Non-allowable advertising	(17,494)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,603

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,411
CCI Allocation	6,344
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,755

**See instructions.

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CEN # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SOUTH SHORE NURSING & REHABILITATION CENTER, L.L.C. # 0042119 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **$4738 - IL COUNCIL ON LTC**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,159** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **131,760**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **7,510** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **25**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw